MICHIGAN ASSOCIATION OF HEALTH PLANS | 2011

WHITE PAPER

MAHP ADVOCACY FOR AN EFFECTIVE HEALTH INSURANCE EXCHANGE IN MICHIGAN

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The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

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Background and Purpose of White Paper

Background

The regulation of health insurance has traditionally been done at the state governmental level. The enactment of Affordable Care Act (ACA), however, represents a historical change in this tradition as this federal law creates significant federal oversight over health insurance markets throughout the United States, including Michigan. The 2000-pages comprising the ACA contain the basic master plan behind the transformation of the marketplace and require that certain reforms take place.

Yet, ACA does not contain a complete blueprint. Rather, the federal government, in many instances, is allowing States to play a role in designing the reform details to meet their unique markets. A theme running through much of ACA is that the federal government is imposing new standards and expectations on the States and if those standards and expectations are not realized, the federal government will step in to lead the transformation and fill in the details of the blueprint.

Simply stated, if Michigan does not react to the timeframes, standards and expectations established in the ACA, the federal government will step in and provide the details of health reform in Michigan. In every major way, the development and implementation of the American Health Benefit (AHB) Exchange and SHOP (Small Market) Exchanges will transform the health insurance market in Michigan. MAHP and members have been very clear on this point—and that the determination of what the Insurance Exchange will look like should and must be a Michigan decision and not one forfeited to the federal government.

The ACA requires exchanges to perform at least 11 specific functions across various fields of endeavor making it difficult to define exactly what the core business of an AHB or SHOP Exchange is. Because of the inherent complexity of the legislation, it is important for MAHP and members to be clear on underlying principles and key advocacy points, while remaining flexible on other issues.

Purpose

The purpose of the *MAHP EXCHANGE WHITE PAPER* is to highlight key points for advocacy of MAHP members and to assist the Snyder Administration and Michigan Legislature in the development and enactment of enabling legislation that makes sense for Michigan.

While not discussed in any detail in this White Paper, MAHP believes that additional legislation beyond just that of establishing an Exchange will be necessary to have successful implementation of the ACA and will assure a competitive Michigan health insurance marketplace.

Michigan has a comprehensive but highly differential scheme for regulating health insurance carriers. Because Michigan's current health insurance regulatory scheme is based on three different sets of regulations (depending on whether the entity is BCBSM, an HMO, or a Commercial Carrier) different rules and oversight apply. This differential scheme is confusing for consumers and other interested parties. It has also led to inequities with the marketplace by affecting access and business potential for health insurance carriers.

The development of the Insurance Exchange will provide the opportunity, if not imperative, to establish the regulatory environment that will enable all carriers to fairly compete for business. Without taking the opportunity to make these changes, the existing uneven regulatory provisions will foster continued confusion and make the administration of Exchanges that much more difficult.

The active participation of legislators and staff in this process is vitally important and MAHP will be providing legislative recommendations for the development of the Exchange in Michigan and for reforming Michigan's current health insurance laws.

Critical Timeline for Legislative Action

The requirement to have an operational Exchange by January 1, 2014, requires that many critical decisions must be made over the next 12-24 months. Due to the minimal performance expectations for Exchanges, Michigan will need to assess such areas as overall standards for exchanges, reinsurance, risk adjustment and rating procedures, consumer access issues, and technology assessment and feasibility.

Health plans will be making business decisions regarding the systems and operational changes they need to make in order to function with a state insurance Exchange—all of which will take time and consume limited resources.

Before those decisions are made (and resources expended by health plans) enabling legislation must be enacted to establish the framework for development, implementation and governance of Michigan's Insurance Exchange. Below is a short list of critical decisions that must be made over the next 24 months to have a functioning Exchange in place by 2014.

2011 Activities by Legislature and Administration

- Determination that Michigan will have its own Exchange
- Enactment of enabling legislation
- Begin and complete feasibility study, review results and begin formulation of a budget for running an Exchange.
- Develop additional enabling legislation for authorization to perform minimal requirements.
- Continue assessment and testing of technology (existing and new) regarding the functions needed for the Exchange and determine state technology capabilities.
- Determine if outside vendors should provide services for operation of exchange.

- Issue interim reports.
- Conduct modeling to outline how the Exchange may be financially self sustainable by 2015.

2012/2013 Activities by Legislature and Administration

- Continue many of the activities began in 2011.
- Determine capabilities regarding interoperability of systems with Medicaid enrollment and new eligibility requirements.
- Continue to monitor, react and implement federal guidance as appropriate for Michigan.
- Develop forms and marketing strategies for consumers and employees of small businesses.
- Continue dialogue with CMS regarding declaration that Michigan will operate its own Exchange.
- Begin planning for transition of high risk pool mechanism into the Exchange.
- Begin actual enrollment via the Exchange prior to January 2014.

Summary

1. The Michigan Legislature must introduce and enact enabling legislation to provide the basic authorization for an Exchange. The National Association of Insurance Commissioners (NAIC) has developed model legislation and ***MAHP is recommending that it be used as the framework with additional considerations outlined in this White Paper.***

2. The Snyder Administration should continue to seek federal assistance to provide resources for Michigan to begin the operation of an Exchange. States can apply for "level one" or "level two" grants for up to $1 million based on their progress with the planning process. Applications for either level are due June 30, or September 30, or December 30 2011. Level two grant applications will also be accepted as of March 30 and June 30, 2012 and offer more flexibility for states.

   In order to be eligible to submit an application for a level two grant, a state must have, among other things, legal authority to establish and operate an Exchange that complies with Federal requirements available at the time of the application.

Core Functions of the Exchange

It is helpful to understand the core roles or functions that Exchanges are intended to provide for citizens. We have outlined the four key themes inherent to the development of a Michigan Insurance Exchange. Exchanges will be a new option for consumers to seek health insurance—but will not be the only means of acquiring health insurance. Therefore, the Exchange will need to coexist with the existing channels for public and private health care coverage—a point conveyed in the following themes.

1. Exchanges as Portals

Consumers and small businesses will first encounter exchanges as electronic portals through which to apply for both private and public healthcare coverage. The Exchanges won't be the only avenue to apply for either private or public coverage, but they are expected to be well-publicized, convenient and consumer-friendly.

Exchanges must be able to determine if individual applicants are eligible for subsidized coverage through the Exchange's Qualified Health Plans, for small employer coverage with employer tax credits (SHOP), for Medicaid, for MI CHILD and for other state-administered public programs, or none of the above. Exchanges must use a "no wrong door" approach in guiding consumers to the source of coverage that is appropriate for them.

2. Exchanges as Resources for Consumers and Small Businesses

An Exchange must provide consumers with a variety of resources to help them shop on the Exchange for insurance coverage that is appropriate for them. An Exchange must operate a toll-free hotline and an Internet website that provides standardized comparative information on health plans. It must assign a rating to each qualified health plan in the Exchange marketplace and must use a standard format for presenting health benefits plan options in the Exchange.

An Exchange must establish a program to reach out to various populations and is to do this by awarding grants to "Navigators," which are entities that conduct public education activities, distribute fair and impartial information about and facilitate enrollment in Exchange qualified health plans, and provide referrals to appropriate venues for qualified health plan enrollees with a grievance, complaint or question regarding their health plan coverage.

3. Exchanges as Marketplaces

In addition to being a gateway for applicants for both public and private healthcare coverage, an exchange will be a marketplace that provides access to minimum essential health coverage (packaged in tiers coinciding with the color codes of "gold," "silver," and" bronze") insured by Exchange-qualified health plans. The Exchange is expected to provide the means for individuals and small businesses to make informed choices regarding standard benefit packages.

The Insurance Exchange marketplace for individuals will be the only avenue whereby individuals can use subsidies (premium assistance tax credits) to purchase health insurance. Similarly, the small business or SHOP exchanges will be the only marketplace in which employees of eligible small employers will be able to purchase coverage that allows their employer to claim a tax credit.

4. *Exchanges as Market Facilitators*

An Exchange must certify qualified health plans to participate in this new marketplace, and must implement procedures for the certification, recertification and decertification of health plans as qualified health plans. Rules for certification will be set by the U.S. Department of Health and Human Services (HHS). Criteria for what the rules must cover are set forth in the ACA.

An exchange must require health plans seeking certifications as qualified health plans to submit a justification for any premium increase. An exchange must also require health plans seeking certification to make public and submit to the Exchange, HHS and the Michigan Office of Financial and Insurance Regulation (OFIR) a list of information including claims payment policies, claim denial data, financial disclosures, and enrollment/disenrollment data. Exchange qualified health plans can only be offered by commercial insurers, HMOs and Blue Cross plans that are licensed by OFIR.

MAHP's Vision for a Michigan American Health Benefit and SHOP Exchange

With the above information as background, MAHP members have agreed upon a recommended vision for Michigan's Insurance Exchange which is now part of our advocacy on the development of the Exchange and is listed below along with the desired characteristics:

> ***MAHP VISION FOR INSURANCE EXCHANGE: "Consumers will be enabled to make informed decisions regarding health insurance coverage and insurers will be able to freely compete in an equitable marketplace that encourages innovation, quality and price competitiveness."***

Desired Characteristics of the Insurance Exchange:

1. An Exchange must recognize the "local" nature of delivery of care;
2. An Exchange must allow regional differences to be reflected in choices for customers, including choice of health plan;
3. An Exchange must create an attractive risk environment;
4. An Exchange must be operated efficiently and with dedication toward serving unique markets and customers; and
5. An Exchange should start small—build on success.

Michigan Insurance Exchange Planning Process (to date)

In September 2010, Michigan was awarded nearly $1 million for a 12-month Exchange planning and establishment grant. This effort was intended to provide a wide scale opportunity for input from stakeholders. Following a stakeholder conference held earlier this year, the Department of Community Health solicited recommendation from stakeholders to participate in an intense process of subgroups to review aspects of how the Exchange might work in Michigan. Subgroups of up to 30 individuals, representing a broad base of stakeholders, were assigned to five different workgroups: Governance, Business Operations, Finance & Evaluation, Regulatory & Policy, and Information Technology. MAHP members were selected to participate in all five subgroups.

The process operated under a consensus recommendation model—with consensus being reached once two-thirds of the workgroup were in agreement. The workgroup process was completed on April 7, 2011, and the consensus recommendations were presented to an exchange steering committee of state officials. The state steering committee will consider the workgroup consensus recommendations in making its report and recommendations to Governor Snyder and the Legislature about establishment of an exchange in Michigan.

Summary of Michigan Stakeholder Work Group Recommendations

Time and space do not allow for a discussion in this White Paper of the extensive materials reviewed by stakeholders or all of the recommendations by each of the five subgroups. However, the following are the major work group recommendations, most of which align with the principles and vision adopted by MAHP:

Stakeholder Workgroup Consensus Recommendations on the Exchange Structure, Governance and Operations

- Michigan should have individual and small employer exchanges that are administered and governed collectively together.
- The combined exchange should be an independent public authority that functions as a market organizer, not an active purchaser.
- The Exchange should have a stakeholder board of 11 voting directors appointed by the Governor to represent buyers, sellers, and experts, two voting directors who are state officials, and the Insurance Commissioner, who does not vote.
- The Exchange should impose no additional certification criteria on carriers or plans beyond those set forth in the ACA, but it should have the flexibility to limit the number of different plans offered by a carrier.
- The exchange should not replace either the individual or small business market, but rather should coexist with current markets.
- Michigan should allow employers of up to 100 workers to purchase through the SHOP exchange.

- The exchange should seek expert advice to design an overall evaluation system of all the functions and intended outcomes of the exchange and participating carriers.
- It should have an annual financial audit and follow FASB or GASB, as appropriate.
- The state has several existing IT systems with which an exchange could interoperate to determine subsidy eligibility.

Unresolved Issues from MDCH Stakeholder SubGroups

It is also important to note that the MDCH stakeholder workgroups did not address certain issues and were unable to arrive at a consensus for others important concerns that will directly affect the development and operation of an Exchange. The legislature will now have to insert its best thinking on how to address the following important issues or to agree upon a process for how to reach consensus.

General Issues Unresolved or Not Discussed

1. The governance stakeholder workgroup considered, but was unable to resolve, the question of whether the exchange should have combined or separate risk pools for individual and small employer coverage. ***(MAHP recommends maintaining separate risk pools)***

2. The various stakeholder workgroups did not consider recommendations of whether Michigan should merge its individual and small employer markets outside of an Exchange. ***(MAHP recommends that the individual and small market remain separate outside of the Exchange)***

3. The various stakeholder workgroups did not consider recommendations regarding what steps an Exchange should take to prevent fraud, waste and abuse. ***(MAHP recommends that enabling legislation should include requirements for active programs consistent with that advocated for the Medicaid Inspector General Legislation)***

4. The business operations work group did not consider a recommendation that, to guard against adverse selection, an Exchange should not have open enrollment periods more frequently than the annual and special open enrollment periods specified by the ACA. ***(MAHP recommends that the Exchange limit open enrollment to an annual open enrollment and those special periods specified by the ACA.)***

Medicaid Eligibility and State System Interaction

5. The various stakeholder workgroups did not consider recommendations regarding whether Michigan should build its own Exchange information technology system, partner with other states, or purchase a commercial off-the-shelf system. ***MAHP has advocated for separating Medicaid Eligibility from the current State System (Bridges) in anticipation of the need to automate eligibility and enrollment for effective interoperability with the Insurance Exchange.***

6. The various stakeholder workgroups did not consider recommendations regarding how involved the Exchange should be with making eligibility determinations for Medicaid and MI CHILD. ***MAHP has advocated for merging Medicaid and MI CHILD and for extending eligibility to annual, from current monthly requirements***. These changes will align with the Exchange operations and create a user friendly and accountable system for consumers, providers, carriers, and avoid more costly alternatives.

Serving Michigan's Low-Income Uninsured: Insurance Exchange or Basic Health Plan Option

7. Interestingly, no stakeholder workgroup considered or developed recommendations regarding whether Michigan should serve residents with incomes between 133% and 200% of the federal poverty level (FPL) through an Exchange OR through an option provided within the ACA for development of a "Basic Health Plan." **MAHP has no formal position regarding the "Basic Health Plan" option. However we believe that its absence from the MDCH stakeholder subgroup meeting discussions was a significant omission and should be one of first considerations undertaken once the Exchange framework has been established through enabling legislation.** In Appendix 3 of this paper, MAHP has created a grid to summarize key issues regarding components of a Basic Health Plan option versus coverage under the Exchange.

All of the above issues are important to Michigan health plans, consumers and small businesses. The Administration and Legislature should continue to seek the views of stakeholders on these issues as it proceeds with the Exchange planning and implementation process.

MAHP Enabling Legislation Recommendations

While much debate will continue nationally and in Michigan regarding Insurance Exchanges, it is clear that in any recommended form, enabling legislation will be necessary. Therefore, the awareness of key issues will be important for legislators and their staff. As a starting point, MAHP recommends that **any enabling statute be based on the NAIC model legislation and include provisions for the following administrative and operational issues that are consistent with the MAHP Vision for the Insurance Exchange. (We have noted the position taken by the various MDCH Stakeholder Subgroups on each issue).**

Further, MAHP recommends that enabling legislation take the "minimalist" approach. That is, because of the dynamics underway in health care overall, and the uncertainty of future federal guidance, Michigan enabling legislation should only address the essential issues at this point:

1. **Enabling legislation** should establish the Exchange as a market organizer, rather than a government regulator or selective contracting agent or an active purchaser. This is true for small

business as well as individual exchanges. ***(MDCH Business Operations work group also recommended this.)***

2. **Enabling legislation** should recognize that the individual market and the small business market, served within the Exchange, should coexist with the current individual market and small group market operating outside of the Exchange, such that there is a minimum of change to the current individual and small group markets. ***(MDCH Business Operations work group recommended that the individual and small group markets outside of the Exchanges continue to exist.)***

3. **Enabling legislation** regarding the individual and small business Exchanges should promote combined administration and operations to avoid inefficiencies, but governance and market considerations need to be tailored to each market separately. ***(MDCH Governance work group recommended that the individual and small business Exchanges have combined administration, operations and governance.)***

4. **Enabling legislation** should promote only annual and special open enrollment periods specified by the ACA to guard against adverse selection. ***(The MDCH Business Operations work group did not consider whether or not to recommend this during its discussions on adverse selection.)***

5. **Enabling legislation** should limit health plan participation in Michigan Exchanges to authorized HMOs, licensed commercial insurers and BCBSM and only those other entities specifically guaranteed participation under the ACA. ***(MDCH Business Operations work group recommended this.)***

6. **Enabling legislation** should prohibit any additional requirements for health plans beyond that of the ACA and current state licensing requirements to be an "Exchange qualified health plan." ***(MDCH Business Operations work group recommended this.)***

7. **Enabling Legislation** should advocate that the Exchange use current and well-respected industry assessment tools (HEDIS, CAHPS, Medicaid "star rating," etc. to evaluate participating health plans rather than establishing new standards.) ***(MDCH Finance & Evaluation work group discussed criteria for evaluating Exchanges and their participating carriers, but did not recommend specific assessment tools.)***

8. **Enabling legislation** should specify the financing mechanism for Exchanges rather than leaving this to administrative decisions. ***(MDCH Finance & Evaluation work group discussed various financing options, but did not specifically recommend whether they should be created in statute or in administrative decisions or rules.)***

9. **Enabling legislation** should assure that a decision-making process for key operational and design criteria are in place to address such issues as: risk adjustment, technology, cost projections, and whether to implement a "Basic Health Plan" option.

Appendix 1
Web Links to References and Resources

The following are web links used in development of this MAHP White Paper. They are also intended to assist MAHP members in understanding the evolving issues related to an Insurance Exchange. The links are arranged by topic to make specific resources easier to locate.

Estimates of Exchange enrollment & cost

1. http://www.rand.org/pubs/technical_reports/2010/RAND_TR825.pdf
2. http://www.chrt.org/publications/cover-michigan/issue-brief-2010-06-impact-of-health-reform-on-coverage-in-michigan/
3. http://www.urban.org/publications/412310.html
4. http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2011/May/Risk-Adjustment-Under-the-ACA.aspx?

State Implementation of Exchanges

1. http://www.statecoverage.org/files/Health%20Benefit%20Exchanges%20An%20Implementation%20Timeline%20for%20State%20Policy%20Makers.pdf
2. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf
3. http://www.urban.org/UploadedPDF/412335-Reaching-the-Eligible-Uninsured.pdf
4. http://www.cbpp.org/files/5-18-11health.pdf

Exchange Model Laws

1. http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf
2. http://www.nasi.org/research/2011/designing-exchange-toolkit-state-policymakers

Regular Updates on Health Reform Implementation

1. http://www.statereforum.org/
2. http://healthreform.kff.org/
3. http://www.statecoverage.org/health-reform-resources
4. http://www.ncsl.org/IssuesResearch/Health/tabid/160/Default.aspx
5. http://www.naic.org/index_health_reform_section.htm

AHIP and MAHP

For a national perspective of the Insurance Industry, America's Health Insurance Plans (AHIP) has created a tool box for state legislators. The link for this "tool box" is: www.ahip.org/legislators

Topics include all facets of federal health care reform, including information on the development of Insurance Exchanges.

Finally, readers of this White Paper may also find updated issues and topics on federal health care reform on the MAHP Website: www.mahp.org

APPENDIX 2

TABLES ON EXISTING REGULATORY REQUIREMENTS FOR HEALTH PLANS

OTHER REQUIREMENTS AN EXCHANGE MAY ESTABLISH

ACA SEC1311(c) QHP MINIMUM EXCHANGE CERTIFICATION REQUIREMENTS
Table 5

QUALIFIED HEALTH PLAN MINIMUM REQUIREMENTS
Table 4

ACA BROAD INSURANCE MARKET REFORMS
Table 3

MI MEDICAID HEALTHPLAN REQUIREMENTS
(Table 2)

MI REQUIREMENTS FOR LICENSURE IN GOOD STANDING
(Table 1)

TABLE 1:

MICHIGAN REQUIREMENTS FOR LICENSURE AND GOOD STANDING

REQUIREMENTS	BCBSM	HMOs	Insurers
Financial Soundness	http://legislature.mi.gov/doc.aspx?mcl-550-1204a	http://legislature.mi.gov/doc.aspx?mcl-500-3551	http://legislature.mi.gov/doc.aspx?mcl-218-1956-4
Governance	http://legislature.mi.gov/doc.aspx?mcl-350-1980-3	http://legislature.mi.gov/doc.aspx?mcl-500-3511	http://legislature.mi.gov/doc.aspx?mcl-218-1956-13
State approval of premiums and products	http://legislature.mi.gov/doc.aspx?mcl-350-1980-6	http://legislature.mi.gov/doc.aspx?mcl-500-3525	
Network adequacy/service area	http://legislature.mi.gov/doc.aspx?mcl-350-1980-5	http://legislature.mi.gov/doc.aspx?mcl-500-3509 http://legislature.mi.gov/doc.aspx?mcl-500-3530	http://legislature.mi.gov/doc.aspx?mcl-Act-233-of-1984
Provider Credentialing/ Contracting	http://legislature.mi.gov/doc.aspx?mcl-350-1980-5	http://legislature.mi.gov/doc.aspx?mcl-500-3528 http://legislature.mi.gov/doc.aspx?mcl-500-3529	http://legislature.mi.gov/doc.aspx?mcl-Act-233-of-1984
Complaints & Appeals	http://legislature.mi.gov/doc.aspx?mcl-Act-251-of-2000	http://legislature.mi.gov/doc.aspx?mcl-Act-251-of-2000 http://legislature.mi.gov/doc.aspx?mcl-500-3513	http://legislature.mi.gov/doc.aspx?mcl-Act-251-of-2000
Fair marketing practices	http://legislature.mi.gov/doc.aspx?mcl-550-1402	http://legislature.mi.gov/doc.aspx?mcl-218-1956-20	http://legislature.mi.gov/doc.aspx?mcl-218-1956-20
Quality Improvement Standards & Reporting	http://legislature.mi.gov/doc.aspx?mcl-350-1980-5	http://legislature.mi.gov/doc.aspx?mcl-500-3508	http://legislature.mi.gov/doc.aspx?mcl-550-56
Consumer Information and Data reporting		http://legislature.mi.gov/doc.aspx?mcl-500-3580	

TABLE 2:

MICHIGAN MEDICAID HEALTHPLAN REQUIREMENTS

(In addition to Table one requirement listed as HMO)

Type of Requirement	Medicaid Health Plan requirements under current contract with the State of Michigan
Compliance	Observance of State, Federal and local laws Compliance with CMS Regulations, HIPAA, Medicaid Policy, False Claims Act, Advanced Directives,
Data reporting	Consumer survey, HEDIS Data Submission, Encounter Data Submission, Claims Reporting
Access	Medicaid Specific provider contracting requirements
Quality	Accreditation/Certification Requirements (NCQA/URAC) Quality Assessment and Performance Improvement Program External Quality Review Performance Monitoring Provider Credentialing
Program Integrity	Prohibited Affiliations with Individuals Debarred by Federal Agencies Program Integrity Review of Provider Payments
Complaints & Appeals	Medicaid Specific grievance and appeal procedures, including expedited procedures

Table 3:

ACA BROAD INSURANCE MARKET REFORMS
(Applies to All Carriers—except those grandfathered)

ACA Broad Insurance Market Reforms	Effective Date
Elimination of Annual & Lifetime coverage limits	Sept 2010
Limits on Rescissions	Sept 2010
Coverage without cost sharing for preventive health services	Sept 2010
Extension of Dependent Coverage	Sept 2010
Elimination of Preexisting Condition exclusions	Sept 2010 <19, 1/1/14 all others
Uniform coverage explanation documents	2012
Public information on claims payment and rating practices	Sept 2010
Rebates for failure to meet minimum loss ratios	Jan 1, 2011
State & federal review of unreasonable premium increases	2010 plan year
Web portal to identify affordable coverage options	May 1, 2010
States must establish one or more geographic rating areas	1/1/14 for individual & small group markets
Premium variation limited to age, tobacco use, geography, family size	1/1/14 for individual & small group markets
Must include minimum essential benefits	1/1/14 for all non grandfathered plans
Guarantee issue during open enrollment; guaranteed renewability	1/1/14 all non grandfathered insured plans
Eligibility rules based on health status prohibited	7/1/14 for all non grandfathered individual market plans

TABLE 4:
QUALIFIED HEALTH PLAN MINIMUM REQUIREMENTS

Certified by an Exchange as per Section 1311(c)
Provides the essential health benefits package
Is offered by a health insurance issuer that is state licensed, in good standing
Is offered by a health insurance issuer that agrees to offer one silver and one gold plan on the exchange
Is offered by a health insurance issuer that agrees to charge the same premium for each qualified health plan offered both inside and outside an exchange.

TABLE 5:

ACA SECTION 1311 (c) MINIMUM EXCHANGE CERTIFICATION REQUIREMENTS FOR QUALIFIED HEALTH PLANS

Marketing requirements
Adequacy of provider choice/network adequacy
Inclusion of essential community providers
Accreditation by an entity recognized by the HHS Secretary
Implement a quality improvement strategy
Use NAIC uniform enrollment form
Use standard format to present benefit options
Provide information on quality measures for health plan performance
Report on pediatric quality measures

Appendix 3: Grid on Basic Health Plan

GRID OUTLINING COMPONENTS ON BASIC HEALTH PLAN OPTION AND INSURANCE EXCHANGE

Products/Premiums	Exchange	Basic Health Plan
133% - 150% FPL	Minimum Essential Benefits. Actuarial value levels: 60% (a bronze plan), 70% (a sliver plan), 80% (a gold plan), and 90% (a platinum plan). Cost sharing capped at 6%. Premium capped at 3-4% of the applicant's income.	Minimum Essential Benefits. Member premiums cannot exceed the premium of the second lowest cost silver tier plan in the exchange (adjusted for any premium credits). Cost sharing capped at the platinum level (10%). Premium capped at 3% - 4% of income.
150% - 200% FPL	Minimum Essential Benefits. Actuarial value levels: 60% (a bronze plan), 70% (a sliver plan), 80% (a gold plan), and 90% (a platinum plan). Cost sharing capped at 13%. Premium capped at 4% to 6.3% of income.	Minimum Essential Benefits. Member premiums cannot exceed the premium of the second lowest-cost silver tier plan in the exchange (adjusted for any premium credits). Cost sharing capped at gold level (20%). Premium capped at 4 % to 6.3% of income.

State Considerations	Exchange	Basic Health Plan
Federal Contributions	Federal subsidies = 100% of exchange premium credits + exchange cost sharing subsidy paid to enrollees. Exchange premium credits = second-lowest-cost silver tier premium – maximum premium based on % of income.	Federal subsidies = 95% of exchange premium credits + exchange cost-sharing subsidy paid to state. Premium credits are based on second least expensive silver plan sold on an exchange. High exchange premiums raise BHP payments.
State Budget Impact	Unknown. Depends on how a state chooses to fund a self-sustaining exchange.	State surplus or deficit = federal subsidies – BHP state costs (net of member components). Average federal BHP payments, based on the cost of subsidies for private insurance in the exchange, will exceed by 29 percent what it would cost Medicaid to cover BHP-eligible individuals. Any surplus must be in a trust fund and can only be used to reduce premiums and/or cost sharing or to provide additional benefits. To the extent that Michigan Medicaid and private insurance costs are different from the above cited national average, any estimated state surplus will differ from the 29% national estimate.
Service Cost	None, unless a state chooses to offer its own health insurance plan within an exchange.	State may contract with licensed HMOs, insurers, or provider networks established to offer BHP services. HMO and insurer BHP plans must have 85% MLR.

State Considerations	Exchange	Basic Health Plan
Administrative Costs	Unknown. Depends on how a state chooses to fund a self-sustaining exchange.	State could provide Medicaid, CHIP, & BHP coverage through same health plans, limiting administrative costs due to program churn.
Access & Affordability	Subsidies are available to citizens with incomes between 133% and 400% FPL who are not eligible for Medicaid, Medicare, CHIP or affordable ESI with minimum essential benefits. Also lawful immigrants with incomes below 100% FPL. Not available to BHP eligibles.	Available to citizens with incomes between 133% and 200% FPL not newly eligible for Medicaid, Medicare or affordable ESI with minimum essential benefits. Also lawful immigrants with incomes below 133% FPL and not eligible for Medicaid.

Consumer Considerations	Exchange	Basic Health Plan
Family Continuity	Medicaid and CHIP plans will have different provider networks than Exchange plans.	BHP plans could be required to have providers that also offer Medicaid and CHIP coverage.
Plan/Provider Choice	Broader choice of plan and provider options than in BHP.	Fewer mainstream, commercial plan options in BHP. Lower provider reimbursement could mean less participation and less choice.
Out of Pocket Cost	40% for bronze, 30% for silver. Cost sharing subsidies only available to those who choose a silver plan. Cost sharing is capped at 6% for those with incomes between 133% to 150% FPL and at 13% for incomes between 150% to 200% FPL.	States have the option to design a BHP with less cost sharing, from little or no cost sharing to a 10 % cost sharing cap for those with incomes between 133% to 150% FPL and 20% cost sharing cap for incomes between 150% to 200% FPL.

Market Impacts	Exchange	Basic Health Plan
Potential Enrollment	Without BHP, 16% of residents. With BHP 14% of residents.	BHP implementation could reduce from 8% to 6 % the proportion of non-elderly residents receiving individual exchange coverage.
Selection Effects	Premiums on exchange could be higher because of competition from BHP.	HHS could allow states to adopt policies to require BHP plans be subject to ACA risk adjustment and reinsurance program
Leverage Effects	Fewer covered lives reduces leverage of exchange plans to cut costs and improve quality	More covered lives improves state's leverage to cut costs and improve quality

Sources for Basic Health Plan Option:

- http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf
- http://www.familiesusa.org/conference/health-action-2011/speaker-materials/NHELP-Paper-Basic-Health-Option.pdf
- http://www.familiesusa.org/conference/health-action-2011/speakermaterials/EBenjamin_FUSA-BHP-presentation_HA-2011.pdf.
- http://healthreform.mckinsey.com/~/media/Extranets/Health%20System%20Reform/Intels/Health%20Intel%20Basic%20Health%20Plan_032411.ashx
- http://www.statecoverage.org/files/TheBasicHealthProgramOptionUnderHealthReform.pdf

Notes Related to Grid: *Premium subsidies for Basic Health enrollees must be at least as generous as those in the Exchange. One provision in § 1331 of ACA suggests that a state may charge slightly higher cost sharing in Basic Health. However, this provision is inconsistent with another subsection, and appears to be due to a drafting error.*
For those with income below 150% FPL, § 1331(a) (ii) states that the maximum actuarial value of the Basic Health plan must be 90% (platinum plan level), and for those above 150% the maximum is 80% (gold plan level). The respective exchange percentages are 94% and 87%, and there is also a reduction of the out-of-pocket limit. The conflict is with § 1331(d) (3) (A), which references the cost-sharing subsidies under § 1402 (relating to Exchanges).

The U.S. Department of Health and Human Services (HHS) could address this conflict by requiring states to use the same cost-sharing levels for Basic Health as in the Exchange. §1331(d) (3) requires the Secretary to determine the amount to transfer to the state on a per enrollee basis, taking into account all relevant factors necessary to determine the value of premium tax credits and cost sharing reductions that would have been provided, including the age and income of the enrollee, whether the enrollment is for self or family, variance in health care spending based on geographic differences in average spending for health care, and the health status of the individual. It is to be based on the experience of other states, with a particular focus on enrollees with income below 200 percent of FPL.